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ADMINISTRATOR

HEALTH CARE FINANCING ADMINISTRATION

ON THE "STATE CHILDREN'S HEALTH INSURANCE PROGRAM

BEFORE THE HOUSE COMMERCE COMMITTEE

SUBCOMMITTEE ON HEALTH & ENVIRONMENT

SEPTEMBER 18, 1998

Chairman Bilirakis, Congressman Brown, distinguished Subcommittee members, thank you for inviting us here today to discuss our progress in implementing the State Children's Health Insurance Program. The State Children's Health Insurance Program, or "CHIP," has provided us with a landmark opportunity to improve children's health and help working families who do not earn enough to afford coverage for their children. This historic, bipartisan achievement is an excellent example of how Congress, the Administration, and States can work together constructively to genuinely improve the lives and health of American children. We greatly appreciate your hard work and the work of Chairman Bliley, Congressman Dingell and other members of the Commerce Committee in securing passage of this critical legislation.

Reversing an Unhealthy Trend

The CHIP program was created through the bipartisan Balanced Budget Act just one year ago to address the fact that more than 10 million American children -- one in seven -- are uninsured and therefore at significantly increased risk for preventable health problems. Many of these children are in working families that earn too little to afford private insurance on their own but too much to be eligible for Medicaid. Unfortunately, the number of uninsured children has been rising.

The number of uninsured children rose from 8.2 million in 1987 to 10.6 million in 1996 -- from 13 percent to 16 percent of all children. The number of children covered through their parent's employer-based plans is also down, from 67 percent in 1987 to 59 percent in 1995.

With aggressive outreach and implementation of CHIP, we hope to help reverse the trend of rising numbers of uninsured children. Already we have approved 40 plans that are expected to cover more than two million children by the end of FY 2000. Outreach efforts are critically important to help us find those children who are eligible for Medicaid but not enrolled, further increasing the number of children who are able to get the care they need to go on to lead long, healthy, productive lives.

Implementation of CHIP has really gotten off the ground in the last six months. We have approved about three-quarters of the 40 State plans since April 1. Because most of the states have just started to enroll children, spending for CHIP has been slower than we originally projected for FY 1998. Our latest estimates indicate that federal spending on CHIP will exceed $600 million for this year. This slow start does not mean that Congress appropriated too much money for the program. States also are applying to expand their programs, and this will further increase spending. We project that all of the CHIP funds will be spent over the next ten years as states expand their programs and enroll more uninsured children.

Outreach to children for both CHIP and Medicaid is one of our biggest challenges. In order to take advantage of this historic opportunity, we must all work together to find those children eligible for these programs and make sure that they are enrolled and receiving the health care they need. The Administration has initiated a comprehensive effort with the states, private companies, advocacy organizations and others. We need to continue to work with our partners and the Congress to ensure that children are enrolled.

What is CHIP

Congress and the Administration wisely agreed to set aside $24 billion over five years to create the Children's Health Insurance Program -- the largest health care investment in children since the creation of Medicaid in 1965. These funds cover the cost of insurance, as well as outreach services to get children enrolled and reasonable costs for administration. To make sure that funds are used to cover as many children as possible, funds must be used to cover previously uninsured children, and not to replace existing public or private coverage. Important cost-sharing protections also were established so families would not be burdened with out-of-pocket expenses they could not afford.

The statute sets broad outlines of the program's structure, and establishes a partnership between the Federal and State governments. States are given broad flexibility in tailoring programs to meet their own circumstances. States can create or expand their own separate insurance programs, expand Medicaid, or combine both approaches.

States can choose among several benchmark benefit packages, develop a benefit package that is actuarially equivalent to or better than one of the benchmark plans, or use the Medicaid benefit. States also have the opportunity to set eligibility criteria regarding age, income, resources, residency, and duration of coverage within broad Federal guidelines. The Federal role is to provide technical assistance to the states and ensure that programs

meet statutory requirements that are designed to ensure meaningful coverage under the program.

Success is a Priority

Making the Children's Health Insurance Program a reality is one of this Administration's highest priorities. We have worked closely with States, Congress, the Health Resources and Services Administration and other Federal agencies to meet the challenge of implementing this program and defining its parameters, while at the same time approving State plans as quickly as possible. We have provided extensive guidance and interim instructions so States can develop their plans and start using Federal funds to begin insuring children at the earliest possible date.

We began by providing States with a draft template, or standard format, to help them provide information that is required by the statute. We have sent more than a dozen letters to State health officials regarding specific policy issues, including outreach, financial issues, and cost sharing. We also have released five sets of detailed answers to important policy questions. All these documents are available on the Internet, providing easy access and quick reference for all interested parties. Since the law was passed in August 1997 and the money became available October 1, 1997, we have been working diligently to approve plans and provide guidance at the same time.

We have worked carefully and diligently to review proposals and help States meet statutory requirements. We approved the first State plan, for Alabama, this January -- just five months after the legislation was signed. As of today, I am proud to report that we have approved 40 plans, including 37 States, two territories, and the District of Columbia. We have only a few more State plans to review.

Each State with an approved plan has a 10-year Federal commitment of at least $2 million per year. The statute gives States three full fiscal years to spend each fiscal year's allotment, which is critically important because already States are expanding their initial programs to insure even more children. Alabama, the first State with an approved plan, also became one of the first States to secure Federal approval to expand its program on August 18. Alabama's extension will cover thousands more children and allow the State to receive as much as an additional $18 million of the FY 1998 allotment to which the State is entitled. More than a dozen States have indicated that they intend to expand these initial submissions. This is a trend we must and will encourage.

Of the plans approved so far, 11 are for programs the States created, 20 are Medicaid expansions, and nine are combinations of State programs and Medicaid expansions. A progress report showing this information by State is attached to this testimony. We expect the mix to change as States expand their initial submissions. States have taken advantage of the flexibility provided to them. Connecticut created the HUSKY program which expands Medicaid and models a program for higher income children on its State employee health plan. New York expanded its existing CHPLus program in which the

State subsidizes private coverage. And Michigan created the MIChild program, which mirrors the State employee plan and is administered by multiple managed care providers.

Challenges Ahead

We can all be proud of the progress to date in implementing the Children's Health Insurance Program. However, several challenges remain. Perhaps our greatest challenge is reaching out to find and enroll children eligible for coverage under the Children's Health Insurance Program, as well as Medicaid. The Administration has taken a number of steps to help and encourage State outreach efforts, and the President's FY 1999 budget includes several additional proposals to help States find and enroll children.

The Agency for Health Care Policy and Research this year reported that 4.7 million uninsured children are eligible for, but not enrolled in, Medicaid. Several million more are in families with incomes too high for Medicaid but too low to afford private coverage. Without an aggressive, broad-based effort to identify and enroll eligible children, we will not succeed in meeting the full potential of the Children's Health Insurance Program.

Experience with Medicaid suggests that many families do not know that their children are eligible for coverage under Medicaid, let alone under the new Children's Health Insurance Program. There is a remaining stigma related to Medicaid's old tie to welfare, and the application process has all too often been long and unduly complicated. Cultural issues, such as difficulty in language comprehension, also have posed barriers.

The President's FY 1999 budget would give States both the funds and the flexibility to find and enroll hard-to-reach children. It would allow States to let schools, child care resource and referral centers, and others who have contact with children, to facilitate enrollment into both Medicaid and the Children's Health Insurance Program.

The President's FY 1999 budget also would broaden use of an existing $500 million fund States may use to make sure children who are no longer enrolled in welfare continue to receive Medicaid benefits for which they are eligible. Few States have used these funds, partly because of the difficulty of targeting such a narrow group. Under the President's plan, Medicaid would pay $9 of every $10 spent by States for outreach efforts to all uninsured children who qualify for assistance. It also would remove the fund's 2000 sunset date and add another $25 million to the effort.

The President also has launched a Children's Health Insurance outreach initiative to encourage full participation in Medicaid and the CHIP. A Federal Interagency Task Force on Children's Health Outreach has been created with representatives from the White House and eight Federal Departments. The Vice President announced the addition of two more agencies, the Department of Justice and the Small Business Administration. Each Department is responsible for developing an action-oriented plan to assist in children's health insurance outreach efforts, focusing on programs that serve low-income children. We have many programs that can reach families, such as child care assistance and the Earned Income Tax Credit, and we need to make sure that we take advantage of these

programs to get the word out about Medicaid and CHIP availability. The President has challenged the private sector to participate in this important effort, as well.

Other Challenges

One concern is the current cap that limits states from spending more than 10 percent of their program expenditures on administrative expenses. In some States, this limit has restricted funding needed for States to implement new programs. States face substantial start-up costs for activities such as development of data systems and simplified application forms, which must be in place before they begin providing services. We are willing to work with Congress and the States on legislative proposals to ensure that States have the administrative funds they need up front to put these programs into place.

Another key challenge is the need to obtain data and objectively assess how varied State programs are working. Documenting CHIP's success will be essential to its continued strong support. In addition, the law mandates that we send a Report to Congress in 2001 on how well the program is working. We want to work with Congress and the States as we proceed to ensure that we are able to collect the right data so our monitoring and evaluation will be accurate, meaningful, and helpful to all interested parties.

Preventing what's known as "crowd out," or use of CHIP funds to cover children who were already covered privately or through other public programs such as Medicaid, is yet another challenge. The statute requires this because Congress and the Administration want to ensure that as many children as possible are covered by this funding. We will continue to work with Congress and the States to implement this part of the law.

We also need to maintain the careful balance struck in the law between the desire for maximum State flexibility, and the Administration, Congressional, and statutory intent that funds be used to cover uninsured children. Some States have expressed interest in using Children's Health Insurance Program funds to buy coverage for parents. The statute allows for the narrow use of program funds to cover children in family policies, allowing some assistance for parents, when, and only when, it is cost effective in covering the children -- that is, the cost of buying coverage for the family policy cannot exceed the cost of providing care for only the children in the family. We have approved one state plan so far, for Massachusetts, which includes family coverage. Massachusetts is meeting the statutory requirement by purchasing coverage for the family through employer-based plans where the employer is paying a large percentage of the cost.

This Administration will continue to provide states with guidance, technical assistance and support for the outreach efforts to make this program a success. We can and we must do more, and we look forward to working with this Committee and all of Congress to pass the legislation needed to enact outreach activities that will find and enroll eligible children in these vital health insurance programs.

Conclusion

We have made substantial progress in making the Children's Health Insurance Program a reality, but much remains to be done. This is a program that will continue to evolve to meet the needs of children and the individual States who administer it. We expect to see States becoming more and more innovative in tailoring programs to meet their own circumstances. We will see more and more children obtain the health care coverage they need and deserve. We will see our children and our nation become healthier and stronger because of this effort. Congress, the Administration, States, local communities, providers and families all have essential roles to play in getting the job done. To date, our work together has been highly productive, and this effort will remain near the top of my list of priorities. Let us continue in the spirit that has brought us this far. Again, thank you for inviting us to be here today, and I would be happy to answer any questions you might have.

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CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP)

PROGRESS REPORT AS OF SEPTEMBER 17, 1998

STATE		**TYPE OF EXPANSION**			**UPPER**	**STATE ESTIMATED**
	Date approved♦	**Grant**	**Combined**	**Medicaid**	**ELIGIBILITY***	**ENROLLMENT**
TOTAL: PLANS SUBMITTED (50)		**13**	**10**	**27**		**2,289,800*** **
STATES WITH APPROVED PLANS:						
Alabama	01/30/98		X		200%	36,000
Colorado	02/18/98	X			185%	23,000
South Carolina* *	02/18/98			X	150%	75,000
Florida	03/06/98		X		200%	175,000
Ohio **	03/23/98			X	150%	133,000
California	03/24/98		X		200%	500,000
Illinois **	04/01/98			X	133%	40,000
New York	04/01/98	X			185%	360,000
Michigan	04/01/98		X		200%	133,000
Connecticut❖	04/27/98		X		235%	15,000
New Jersey	04/27/98		X		200%	102,000
Missouri**❖	04/28/98			X	200%	90,000
Rhode Island**	05/08/98			X	250%	3,000
Oklahoma	05/27/98			X	185%	71,000
Massachusetts	05/29/98		X		200%	37,000
Pennsylvania**	05/28/98	X			185%	63,000

Wisconsin **	05/29/98			X	100%	2,000
Oregon**	06/12/98	X			170%	17,000
Texas**	06/15/98			X	100%	58,000
Idaho**	06/15/98			X	160%	5,000
Indiana**	06/26/98			X	150%	58,000
Puerto Rico	06/26/98			X	200%	20,000
Utah	07/10/98	X			200%	21,000
North Carolina	07/14/98	X			200%	35,000
Minnesota**	07/17/98			X	280%	-
Maryland	07/31/98			X	200%	15,500
Arkansas**	08/06/98			X	100%	3,600
Nebraska**	08/07/98			X	100%	1,000
Maine	08/07/98		X		185%	10,400
Nevada	08/13/98	X			200%	44,000
South Dakota	08/25/98			X	133%	7,400
Iowa**	09/01/98			X	185%	16,000
Kansas	09/01/98	X			200%	30,000
Delaware	09/01/98	X			200%	10,500
Georgia	09/03/98	X			200%	58,000
Montana	09/11/98	X			150%	9,000
New Hampshire❖	09/16/98		X		235%	4,000
West Virginia**	09/16/98			X	150%	-
District of Columbia	09/17/98			X	200%	8,400
Virgin Islands	09/17/98			X	Not available	-
TOTAL: STATES/TERRITORIES WITH APPROVED PLANS (40)		**11**	**9**	**20**		
STATES WITH PLANS UNDER REVIEW:						
Tennessee				X	200%	
Vermont (Withdrawn 08/05/98)				**X**	**300%**	
New Mexico				X	235%	
Kentucky			X		200%	
Virginia		X			175%	
Arizona**		X			150%	

North Dakota				X	100%	
Mississippi**				X	100%	
Louisiana				X	200%	
Alaska				X	200%	
TOTAL: STATES WITH PLANS UNDER REVIEW (10)		**2**	**1**	**7**		

NOTES:

♦ Date of appoval of original CHIP plan. Some States already have amendments approved to their plans.

* Upper eligibility is defined as a percent of the Federal poverty level (FPL). In 1998, FPL is $16,450 for a family of 4.

** State either has an amendment pending or has indicated to HHS that the plan submitted is only the first step in a broader expansion. Other States also may be considering second phases of their CHIP plans.

*** The total State estimated enrollment only reflects the approved plans (35 States). These estimates reflect States' unreviewed estimates of enrollment upon full program implementation.

❖ This income level reflects an eligibility level net of adjustments to gross income.